STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235632	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Samaritan	5555 Conner Avenue, Suite 4000 Detroit, MI 48213

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230 This citation pertains to intakes MI145596 and MI145720. Based on interview and record review the facility failed to report an allegation of employee to resident abuse to the State Agency for one resident (R103) of three residents reviewed for abuse, resulting in the potential for feelings of not being protected or safe within the facility, and for abuse to continue without being reported. Findings include: On 7/11/24 and 7/16/24, two complaints were reported to the state complaint hotline alleging employee to resident abuse on behalf of R103. The complainants alleged R103 was attacked by a female staff member (slapped residents arm several times). There was no facility reported incident (FRI) submitted by the facility for the allegation. On 11/6/24 at 10:37 a.m. an investigation submitted by the facility was reviewed and documented on 7/14/24 the Nursing Home Administrator (NHA) was notified of an allegation of abuse by staff R103 reported hit by an aide. The NHA concluded the incident did not occur. On 11/6/24 at 11:30 a.m. NHA was interviewed. The NHA said the incident was not reported to the state agency because a thorough investigation was conducted and could not be substantiated. The NHA added they were instructed not to report the incident to the state agency. Review of the clinical record documented R103 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included malignant neoplasm of mouth, dysarthria and anarthria, dysphonia, macular degeneration, generalized anxiety disorder, depression, chronic kidney disease, stage 3, and glaucoma. According to the admission Minimum Data Set (MDS) assessment dated [DATE] R103 was cognitively intact (BIMS=15) and required limited one person assistance with activities of daily living. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER The Orchards at Samaritan		STREET ADDRESS, CITY, STATE, ZIP CODE 5555 Conner Avenue, Suite 4000 Detroit, MI 48213	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Abuse and Neglect Prohibition Policy dated 2/17/20 documented: .The Administrator or designee is responsible for reporting to the State Agency all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of property: a. Immediately but no later than 2 hours after the allegation is made if the allegation involves abuse or result in serious bodily injury; b. Or not later than 24 hours if the events that cause the allegation do not involve abuse or serious injury.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423 This citation pertains to intake MI00147722 and MI00146334. Based on observation, interview and record review, the facility failed to address changes in laboratory findings in a timely manner for R101 of two residents reviewed for a change in condition, resulting in significant critical laboratory values, delay in treatment, and hospitalization . Findings include: On 11/6/24 at 10:56 AM, R101 was observed in their room, wearing a gown, and sitting in a wheelchair. The resident had mild edema (swelling caused by too much fluid trapped in the body's tissues) in both lower legs. R101 was asked about when they became ill and sent to the ER in October. R101 said that they were feeling weak, dizzy, and short of breathe for a few days and was sent to the hospital to receive a blood transfusion. R101 stated that they were still feeling weak and did not feel like dressing. R101 stated, They said I need some iron. A review of R101's electronic medical record noted an initial admission on 8/18/21 with a diagnosis of Atrial Fibrillation (a heart condition that causes the upper chambers of the heart to beat irregularly), Breast Cancer, Diabetes, Heart Attack, Hypertension (high blood pressure), Covid-19, and Anemia. A review of R101's Brief Interview for Mental Status (BIMS) was 15/15 (intact cognition). A review of R101's care plan noted the following: I have an alteration in my hematological status r/t (related to) DX (diagnosis) of Anemia Date Initiated:8/28/21 .Goal-I will remain free of s/sx (signs and symptoms) or complications related to anemia. Date Initiated 8/28/21 .Revision on 11/29/22 .I will remain free from complications, bleeding, injury r/t use of aspirin .Interventions-Observe me and report any s/sx of anemia .fatigue, dizziness, weakness, SOB (shortness of breath), change in cognition. Date Initiated:8/28/21 .Obtain and monitor lab/diagnostic work as ordered. Report results to my doctor and follow up as needed. Date Initiated: 8/28/21 . A review of R101's Laboratory results noted the following: 5/28/24: HGB results 8.6 (R101on iron supplement) 5/28/24: Iron result 51 (normal range 50-170) 7/8//24: Iron supplement discontinued 7/26/24 HGB results 7.9 7/26/24: Iron level result 37 7/26/26: No evidence of change in plan of care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R101's medication order noted the iron supplement was discontinued on 7/8/24 by Physician D. Record review revealed there was no implementation of interventions to address R101's decreased iron/iron deficiency. There was no evidence of a dietition to address R101's low iron. On 11/6/24 at 2:45 pm, The Director of Nursing DON was queried and was unable to explain why there was no change in the plan of care for R101 when R101 labs related to iron decreased. A review of R101's progress notes dated 10/10 at 1:41 PM noted the following: Resident c/o sob (complained of shortness of breath) when (they) stand, stated it started yesterday, and the nurse administered oxygen. A review of R101's progress notes dated 10/10 at 7:30 PM noted the following: Resident received in fair condition with acute concerns of shortness of breath, increased lower extremity edema, difficulty with urination and dizziness upon standing. Nurse noted resident on 2 liters NC (nasal canula) placed per previous shift .Resident requested to go to the ER (emergency room) for further care related to (their) increased sob. Nurse called to management to update on situation and DON spoke with resident about further care, developed a plan to remain in facility . A review of R101's progress note created by Physician D dated 10/11/24 at 7:45 AM noted the following: Patient (R101) was seen last night dizziness on standing, shortness of breath, labs were collected and dropped at (hospital) lab. Acute anemia .HGB 5.5 (critical level) .start hydration .hold Eliquis and aspirin .was on ferrous sulfate in January for 6 months. Needs blood transfusion. Review of medical record revealed no order to send resident to hospital for blood transfusion at this time. Record review revealed on 10/11/24 at 7:45 am HGB results 5.1 (critically low) with R101 experiencing noticeable symptoms related to their anemia, such as weakness, shortness of breath, and dizziness. A review of R101's progress notes dated 10/11/24 at 8:07 AM noted the following: Nurse received communication from MD (Physician D) for additional orders for STAT labs to be drawn this morning, collect stool sample and send to lab . A review of R101's progress notes dated 10/11/24 at 11:39 AM noted the following: Order received to send the resident to (hospital). Awaiting (Ambulance) to transfer. A review of R101's progress notes dated 10/11/24 at 14:39 AM noted the following: Resident transferred to the hospital. A review of R101's hospital records with admitted [DATE], noted a diagnosis of Anemia, fluid overload, and acute kidney injury. R101 received two units of blood during hospitalization . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/24 at 2:45PM, the Director of Nursing was interviewed and queried about R101's iron supplement discontinued, complaint of shortness of breath, and delay in sending the resident to the hospital. The DON stated, The nurse called me to discuss (R101) condition, but, I was not aware that (R101) had shortness of breath the day before .I discussed with R101 a plan of care and (they) agreed .(R101) was started on one liter of normal saline at 60 ml per hour .(R101) had a chest x-ray that showed an infiltrate (substance that builds up in the lung tissue, such as fluid) .(Physician D) stopped (R101's) iron and did not prescribe anything else for (their) anemia . (Physician D) said that (they) only liked to use iron supplements for a few months and then discontinue . I wanted to treat (R101) with fluids before sending to the hospital .we also gave (R101) oxygen. On 11/8/24 at 11:00AM, Physician D was interviewed and queried about R101's iron supplement discontinued and delay in sending the resident to the hospital. Physician D stated, I usually try six months or iron and then I take the patient (R101) off and monitor the resident .I restarted the iron after (they) were discharged from the hospital .the DON did not want to send (R101) to the hospital .they always fight me about sending the patients to the hospital. A review of the facility's policy Acute Change in Condition noted the following: An Acute Change of Condition (ACOC) is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains .If a plausible cause was not found readily in someone with an ACOC, assess whether delirium, fluid and electrolyte imbalance, infection, and medication related effects is the cause for the ACOC .The following symptoms may suggest ACOC or require additional assessment: Struggling to breathe .New onset of weakness .Dizziness .Bleeding.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230 This citation pertains to intakes MI00145596 and MI00145720. Based on interview and record review the facility failed to ensure scheduled and as needed pain medications were administered per the physician's orders for one (R103) of three residents reviewed for pain management resulting in uncontrolled pain, frustration, anger, and feelings of helplessness. Findings include: On 11/6/24 at 11:57 a.m. the complainant (R103) was contacted and spoken to about the allegations submitted to the state agency complaint hotline on 7/11/24. The complainant said the complaint was made because of multiple daily calls from R103 not getting pain medication ((R103) would literally be in tears begging me to come get him because he was in so much pain. (R103) called me the first night he was there crying because he couldn't get his pain pill. Nobody would answer the call bell.) The complainant also said R103 left the facility due to not receiving decent medical care. Nurse progress note dated 8/20/24 documented R103 left the facility against medical advice. Review of the clinical record documented R103 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included malignant neoplasm of mouth, dysarthria and anarthria, dysphonia, macular degeneration, generalized anxiety disorder, depression, chronic kidney disease, stage 3, and glaucoma. According to the admission Minimum Data Set (MDS) assessment dated [DATE] R103 was cognitively intact (BIMS=15) and required limited one person assistance with activities of daily living. The MDS also documented R103 received scheduled and PRN (as needed) pain regimen and experienced pain or hurting. Review of the hospital discharge report dated 7/3/24 documented additional diagnoses that included mandible (jaw bone) pain, chronic pain due to neoplasm, cancer related pain, and post-operative pain. The discharge report also included a prescription for Oxycodone 5 mg immediate release tablet with instructions to take 1-2 tablets (5-10 mg total) by mouth every 4 hours as needed for up to 3 days, for oral cancer. R103 was administered Oxycodone 10 mg at 3:43 p.m. on 7/3/24 (prior to transfer to facility). Review of the July Medication Administration Record (MAR) documented on July 3rd, evening medications were administered except for the Oxycodone. Record review revealed the facility administered R103 pain medication on 7/4/24 at 9:30 am. R103 did not receive Oxycodone for 17 hours (last dose on 7/3/24 at 3:43 pm). Review of the physician's orders documented the following pain medication regimen to be administered: Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug* Give 10 mg by mouth every 4 hours for pain hold if RR <14. Start date: 7/10/24. Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 10 mg by mouth every 4 hours as needed for as needed for pain Hold if respiratory rate less than 14. Start date: 7/4/24. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug* Give 5 mg by mouth every 4 hours as needed for as needed for pain. Start date: 7/3/24. PLEASE ALL MEDICATIONS MUST BE ADMINISTERED ON TIME every 4 hours for PAIN CONTROL. Start date: 7/10/24. The following Nurse progress notes documented the following: -On 07/03/24 at 18:49 (6:49 pm) Note Text: Patient admitted from hospital at 5pm. He's being admitted due to oral cancer (Para neo-Plastic Syndrome) . -On 07/04/2024 12:49 Note Text: Resident with C/O pain at beginning of shift. Resident medications had not been delivered pharmacy contacted once open at 9am for off (sic) to pull, C2 script was not sent to pharmacy. MD contacted and script was sent, off (sic) to pull for 5mg 1-tab Q4hrs PRN. Resident was given 1 tab at 9:30am. -On 07/09/2024 01:34 (1:34 am) Type: Behavior Note: . was waiting for a pain pill that he arrived too early for . Resident when told he had to wait 20 minutes for his pain medication, began to berate the Nurse, while threatening to report and have the Nurse fired from duty, I'll call the State on you . Nurse provided pain medication at time it was available . -On 8/11/24 00:00 (12:00 am) oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 10 mg by mouth every 4 hours for pain hold if RR <14 was on hold for behaviors. Behaviors were not documented to justify withholding pain medication. -On 08/19/2024 20:06 (8:06 pm) Note Text : Resident observed having emesis throughout the shift c/o of severe pain and cramping. Resident refused to go to radiation. Resident spoke with doctor at treatment center and stated he was having a mental break down. Dr contacted our facility to inform us of the situation. Staff nurse spoke with resident assuring him his medication will come today. Pharmacy contacted and stated medication in route. -On 8/20/2024 03:06 (3:06 am) Type: Nurses Note Text : Resident received in fair condition with current concerns of not having his scheduled Oxycodone for multiple days, resident states his mental health has been affected with the pain and overall condition related to his cancer and treatment involved . Resident states he doesn't feel well, has not slept in a few days . @ 1900 Nurse endorsed ongoing concern of missing oxycodone, script sent on previous shift, Nurse and supervisor attempted to pull medication from back up supply EXCEPT pyxis was empty - No oxycodone 5mg or 10mg was available . Resident continues to feel uneasy, afraid to go to sleep . Review of the following physician's notes documented complaints from R103 about pain: -On 8/19/2024 19:14 (7:14 pm) Physical Medicine Rehabilitation Note Text: Revision of meds. Pain is controlled most of the time. -On 8/12/2024 17:40 (5:40 pm) Physical Medicine Rehabilitation Note Text: Patient was seen today at bedside due to inability to perform ADLs Independently related to Cancer-related pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-On 08/02/2024 11:33 (11:33 am) Physician Progress Notes Text : Medicine Progress: Previously patient had reported that his pain is well-controlled with the pain medication. However, he has been complaining of pain not being controlled to the staff (sic). - 08/01/2024 11:26 (11:26 am) Physician Progress Notes Text: Medicine Progress Note: Uncontrolled pain . Patient states pain is not well controlled. Review of the Pain care plan dated 7/5/24 documented: I have the potential for pain/discomfort r/t removal of oral cavity squamous cell carcinoma stage IV, wound to right leg. Interventions: -Administer my analgesic per orders. Give approx. 1/2 hour - 45 min before treatments or care when needed. -Anticipate my need for pain relief and respond as soon as possible to all and any complaint/signs of pain. - Attempt nonpharmacological interventions prior to giving me medication for pain. On 11/8/24 at 2:03 p.m. the Director of Nursing (DON) was interviewed regarding R103 not receiving pain medication as ordered. The DON did not recall the circumstance surrounding the resident not receiving pain medication due to behaviors. The DON said having behaviors does not justify pain medications to be withheld. Other non-pharmacological interventions could have been implemented or attempted. All medications should be administered per the physician's orders. On 11/8/24 at 3:07 LPN C was the midnight shift nurse for R103. An attempt to contact LPN C was made, however there has been no call back. On 11/8/24 at 1:01 p.m. R103 was contacted, however did not return the call until 11/13/24 at 2:24 p.m. R103 was interviewed and stated, My time at (facility) name) was horrible and I wouldn't wish what happened to me on my worst enemy. Most of my problems happened on the late shift and weekends. The one nurse (didn't remember nurse, confirmed to be LPN C) played God with my pain medications all the time. My pain medications were often not available, or the nurses just didn't want to give it to me. My pain level was always at an 8-9. I am always in constant pain, and I am trying to deal with it the best I can. It's depressing to be in pain all the time. It's more depressing when the people that are supposed to help you make you feel more helpless. Being in pain all the time will make any angry especially when denied the one thing to help make the pain better. I felt ignored when I would ask for my medication and had to wait to get it. I was forced to leave because they wouldn't help me. I had to leave for my own safety. R103 was very emotional and cried during the interview. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled Medication Administration and General Guidelines (no date) documented the following: Medications are administered as prescribed. In accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so . Medications are administered in accordance with written orders of the attending physician . Medications are administered within one hour of the scheduled time, unless the physician specifies a specific time then the med must be given 30 minutes prior to 30 minutes after the specified time (unless facility policy directs otherwise) . If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time . An explanatory note is entered on the reverse side of the record provided for PRN documentation. The physician must be notified when a dose of medication has not been given . Review of the facility's policy titled Pain Management (no date) documented the following: The facility will assess and identify residents experiencing pain, determine the type and severity of the pain and develop a care plan for pain management. The care plan is implemented and continually evaluated for its effectiveness. The staff monitors and documents the resident's response to pain management interventions . The pain experience is very subjective; pain is whatever the resident says it is .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230 Based on interview and record review the facility failed to ensure the proper storage of a narcotic for one (R103) of three residents reviewed for medication administration potentially resulting in a missed dose, medication waste, and misappropriation. Findings include: Review of the clinical record documented R103 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included malignant neoplasm of mouth, dysarthria and anarthria, dysphonia, macular degeneration, generalized anxiety disorder, depression, chronic kidney disease, stage 3, and glaucoma. According to the admission Minimum Data Set (MDS) assessment dated [DATE] R103 was cognitively intact (BIMS=15) and required limited one person assistance with activities of daily living. The MDS also documented R103 received scheduled and PRN (as needed) pain regimen and experienced pain or hurting. Review of the physician's orders documented the following pain medication regimen to be administered: Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug* Give 10 mg by mouth every 4 hours for pain hold if RR <14. Start date: 7/10/24. Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 10 mg by mouth every 4 hours as needed for as needed for pain Hold if respiratory rate less than 14. Start date: 7/4/24. Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug* Give 5 mg by mouth every 4 hours as needed for as needed for pain. Start date: 7/3/24. The following Nurse progress notes documented the following: -On 07/04/2024 12:49 Note Text: Resident with C/O pain at beginning of shift. Resident medications had not been delivered pharmacy contacted once open at 9am for off (sic) to pull, C2 script was not sent to pharmacy. MD contacted and script was sent, off (sic) to pull for 5mg 1-tab Q4hrs PRN. Resident was given 1 tab at 9:30am. Review of the Pyxis (Medication and controlled substance inventory management within an automated dispensing system) record for R103 documented on 7/4/24 at 9:33 am Oxycodone 5mg tablet, quantity 2.00 (2- 5mg tablets) was signed out by LPN A. On 11/8/24 at 9:44 a.m. LPN A was interviewed and asked why two 5mg Oxycodone tablets were signed out when one 5mg Oxycodone tablet was administered. LPN A said the extra tablet was pulled from the back up supply (Pyxis) for the next dose or oncoming shift. I'm guessing that's why I did that. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/24 at 2:16 p.m. the DON was interviewed and asked was it standard of practice to pull and store extra narcotics for the next shift or pull medications to be administered at a later time and date. The DON stated, I would not have pulled unused narcotics from the back up box or store it improperly. That is not how that's supposed to be done. Narcotics should be signed out of the back box at the time it is to be administered. Review of the facility's policy titled Medication Storage in the facility dated 4/1/23 documented the following: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .